

# Montana WIC Application for Local Agency Programs

## I. Instructions:

- A. Contact the State WIC Director to discuss intent to apply for a new local agency program or clinic within an existing program.
- B. Please answer all questions completely (may attach additional pages or references if needed).
- C. Use the most current data available (if available and applicable).

## II. Applicant Information:

- A. Applicant Agency Name: \_\_\_\_\_
- B. Address: \_\_\_\_\_
- C. Telephone: \_\_\_\_\_
- D. Name, title and address of responsible official: \_\_\_\_\_
- E. Applying for: ☐ New Local Agency Clinic (Region) ☐ New Satellite Clinic within existing region

If this application is for a satellite clinic, provide a brief explanation of why an additional clinic is desired or needed:

### F. Type of Agency:

- ☐ Public
- ☐ Private, Non-profit
- ☐ IRS Tax Exempt #: \_\_\_\_\_
- ☐ IRS application pending (Date submitted \_\_\_/\_\_\_/\_\_\_)
- ☐ Tribal
- ☐ Other: \_\_\_\_\_

## III. Please address the following questions related to administrative feasibility:

- A. Are commissioners, Health Officer's, and/or management staff at the local site supportive of starting an independent WIC clinic?
- B. Is there adequate infrastructure to support the WIC clinic?
- C. What equipment will need to be purchased in order to begin operation of a new clinic (i.e. computer, scales, measure/stature boards, hemocue, office furniture, storage cabinets, etc.)? What costs are associated with this and is there existing equipment that could be shared with another public health agency?
- D. If this application is for a new satellite clinic, are there sufficient funds to operate an additional clinic within the existing federal grant?
- E. When do you anticipate being ready to open a WIC clinic?

# Montana WIC Application for Local Agency Programs

- F. How many days per month and hours per day do you anticipate offering WIC services?

## IV. Health Services:

- A. Is there currently pediatric and perinatal care available in your agency or community? If yes, describe:

If no, describe your plans to ensure WIC participants have access to these services:

- B. Describe your plans to refer Program participants to a public agency or private provider for follow-up on identified health problems, including the procedure for feedback from the public or private provider.

## V. Nutrition Services:

- A. Provide the name of the individual who will act as Competent Professional Authority (CPA). A CPA is an individual on the staff of the local agency authorized to determine an applicant eligible for participation, determine nutritional risk and prescribe supplemental foods. The only persons who may be authorized to serve as a CPA are: Physicians, Nutritionists, Registered Dietitians, Registered Nurses, Certified Physician's Assistants, or a medically trained professional with education meeting the criteria in the Montana WIC State Plan:

Note: CPAs must be approved by the State Office.

If no one is currently on staff who meets the criteria as a CPA, what are your plans for recruitment?

- B. What do you anticipate necessary FTE(s) to be? For example, CPA, Aide, office manager, etc. List position title and anticipated FTE(s):
- C. Is there a Registered Dietitian (RD) available to work with high risk participants?

If not, what are your plans for recruiting or contracting with an RD?

## VI. Socio-Economic/Vital Statistics:

- A. What will be your service area (county or reservation)?
- B. What is the service area population?

# Montana WIC Application for Local Agency Programs

- C. What is the service area racial/ethnic composition?
1. White \_\_\_\_\_%
  2. Black \_\_\_\_\_%
  3. Hispanic \_\_\_\_\_%
  4. American Indian \_\_\_\_\_%
  5. Asian or Pacific Islander \_\_\_\_\_%
- D. What is the median family income in your service area?
- E. Which of the following programs are available in your service area? Provide the most current caseload figure (if available/applicable).
1. Temporary Assistance for Needy Families (TANF):
  2. Supplemental Nutrition Assistance Program (SNAP):
  3. Medicaid:
  4. Home Visiting Program (MIECHV):
  5. Other:
- F. What is the incidence of the following for your service area (if available/applicable). Reference the Montana Affirmative Action Plan:
1. Percent Term Births:
  2. Adequate Pre-natal care
  3. Infants on Medicaid %:
  4. Percentage of Food Insecurity:
  5. Ranking order of your county on the Montana Affirmative Action Plan:
  6. Other risks you have identified:

## VII. Financial Management:

- A. Provide a projected 12 month budget for the proposed WIC activities. This should consist of salaries, benefits and operating expenses, include and list any new equipment which will need to be purchased such as weighing and measuring devices
- B. Provide a copy of the most recent financial audit of your agency.
- C. List who will provide expenditure reporting (i.e. WIC Staff, Clerk & Recorder, etc.)?

# Montana WIC Application for Local Agency Programs

## VIII. WIC Caseload:

- A. Provide data (if available) on the current and/or projected caseload for the clinic you would like to open:
- B. Describe your plans for outreach to meet annual requirements for a public announcement of services locally, and effective collaboration/coordination in your community to enroll and retain eligible participants:

## IX. Physical Location:

- A. Describe the location where participants will be served. Be specific (i.e. Health Department, City-County Building, Hospital, etc.). Describe office space, size of space, available waiting area, etc.
- B. Is the space compliant with the Americans with Disabilities Act (ADA) criteria?
- C. Is the space clean, safe and well-maintained?
- D. Describe what secure storage is available for eWIC cards, computer equipment, breast pumps, etc.

## X. Retailer Services:

- A. List name and location of retail stores which are currently authorized or under contract to redeem WIC food instruments; or ones which may be willing to enter into contract (use additional sheets if needed).

The applicant agrees to comply with all non-discrimination and American with Disabilities Act (ADA) regulations as described in Part 7 CFR 246.8.

The applicant further agrees and assures that if selected, it will comply with the WIC Program Federal Regulations and State Policies and Procedures for WIC Program operations. The current state plan may be located at [www.wic.mt.gov](http://www.wic.mt.gov).

The information contained in this application for a WIC Program is true and accurate to the best of my knowledge.

---

Signature of Local Official with Authority to Implement WIC Program

---

Date

---

**State Agency Review:**

## Montana WIC Application for Local Agency Programs

Received Date: \_\_\_\_\_

Reviewed (name and date): \_\_\_\_\_

Decision:    ☐ Approved    ☐ Denied    ☐ On-hold until funds are available

Notification to Applicant (date): \_\_\_\_\_

Comments:

State Director (or designee) signature:

---